STATE OF IDAHO
DEPARTMENT OF INSURANCE
700 WEST STATE STREET, 3rd FLOOR
PO BOX 83720
BOISE, ID 83720-0043

FOR DEPARTMENT USE ONLY	0560 1025 1315-10 TOTAL

STATEMENT OF TAXES AND FEES

HOSPITAL AND PROFESSIONAL SERVICE CORP.

C/A NO.	NAIC NO.

COMPANY NAME	FOR CALENDAR YEAR ENDING DECEMBER 31, 2005
MAILING ADDRESS	DOMICILE STATE

RECAP OF TAXES AND FEES

1. HOSPITAL AND PROFESSIONAL SERVICE CORPORATION TAX (SCHEDULE A) $_____

2. TOTAL OF ALL ATTAHCED SELF-FUNDED PLANS TAX (SCHEDULE C) $_____

3 ANNUAL CONTINUATION FEE for Calendar Year 2006, IDAPA 18.01.44.03.a.vi.: $ 500.00
Payment of fee must be included.

4 ADD PENALTY, IF DUE ($25.00 per day of delinquency - Idaho Code § 41-3928 and 41-3427) $_____

5 TOTAL AMOUNT ENCLOSED: $_____
Make check payable to: **Idaho Department of Insurance**
There will be a $20.00 charge on all returned checks - Idaho Code § 28-22-105
Your canceled check is your receipt

Indicate if payment is by EFT _____.

Under penalty of perjury, I declare that this statement (including any accompanying schedules and statements) has been examined by me and to the best of my knowledge and belief is a true, correct, and complete return.

Contact Person

( )
Telephone Number Ext.

Signature of Officer Date

Name and Title (Type or Print)

SCHEDULE A - HOSPITAL AND PROFESSIONAL SERVICE CORPORATIONS

TOTAL PREMIUMS WRITTEN
ATTACHED Annual Statement, Schedule T, Line 13, sum of Column 3, 4, 5, 6. _____

NET SUBSCRIBERS' (MEMBER) CONTRACTS IN FORCE PER MONTH:

	Members	Subscribers		Members	Subscribers
JANUARY	_____	_____	JULY	_____	_____
FEBRUARY	_____	_____	AUGUST	_____	_____
MARCH	_____	_____	SEPTEMBER	_____	_____
APRIL	_____	_____	OCTOBER	_____	_____
MAY	_____	_____	NOVEMBER	_____	_____
JUNE	_____	_____	DECEMBER	_____	_____
			TOTALS	_____	_____

X $.04 =

TOTAL TAX DUE ON SUBSCRIBERS $_____

Carry forward to Page 1, Recap of Taxes and Fees, Line 1

⇔ **MUST ATTACH ANNUAL STATEMENT:**

EXHIBIT 1 ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS
EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION, STATE OF IDAHO
SCHEDULE T

NAME OF ADMINISTERED PLAN**:** _____

ADDRESS: _____ CITY: _____

NAME OF CONTACT PERSON**:** _____

SCHEDULE C – EACH INDIVIDUAL SELF FUNDED PLANS

NUMBER OF BENEFICIARIES COVERED PER MONTH: Idaho Code § 41-4012

JANUARY	_____	JULY	_____
FEBRUARY	_____	AUGUST	_____
MARCH	_____	SEPTEMBER	_____
APRIL	_____	OCTOBER	_____
MAY	_____	NOVEMBER	_____
JUNE	_____	DECEMBER	_____

TOTAL BENEFICIARIES _____

X $.04 =

TOTAL TAX DUE $_____

Add each to total reported on Page 1, Recap of Taxes and Fees, Line 2